STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED	
		155291	A. BUILDING	00	04/21/2011
			B. WING	-	
NAME OF P	ROVIDER OR SUPPLIER	1		ADDRESS, CITY, STATE, ZIP CODE	
			l l	ALLEY FARMS ROAD	
EAGLE V	ALLEY MEADOWS	5	INDIAN	IAPOLIS, IN46214	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This visit was for	r Investigation of	F0000	The creation and submission	n of
		089400. This visit		this Plan of Correction does	I
	resulted in a part			constitute an admission by t	
	•	-		provider of any conclusion s	et
	survey-immediat	te Jeopardy.		forth in the statement of	ion of
				deficiencies, or of any violat regulation. This provider	on or
	•	089400- Substantiated.		respectfully requests that the	Δ
	Federal/state def	iciencies related to the		2567L Plan of Correction be	
	allegations are c	are cited at F279, F314, and considered the Letter of Cred		•	
	F325.			Allegation and requests a Po	ost
				Certification Review on or a	iter
	Cumusus datas. Am	mil 10 and 10, 2011		May 21, 2011.	
		oril 18 and 19, 2011			
		dates: April 20 and 21,			
	2011				
	Facility number:	000188			
	Provider number	:: 155291			
	AIM number: 10				
	7 HIVI Hamber. 10	0200310			
	C				
	Survey team:	D11 TG			
	Chuck Stevensor				
	Rita Mullen RN	(4/19, 4/20, and 4/21,			
	2011)				
	Census bed type:				
	SNF: 5				
	NF: 5				
	SNF/NF: 92				
	Total: 102				
	Census payor typ	ne.			
	Medicare: 15	,			
	Medicaid: 74				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4DO911

Facility ID:

TITLE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155291	B. WING			04/21/2	011
NAME OF D	ROVIDER OR SUPPLIER		-	STREET A	DDRESS, CITY, STATE, ZIP CODE		
					ALLEY FARMS ROAD		
EAGLE V	ALLEY MEADOWS	3		INDIAN	APOLIS, IN46214		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	īΕ	COMPLETION
TAG	Other: 13	LSC IDENTIFYING INFORMATION)		TAG	BEIGHNOT		DATE
	Total: 102						
Sample: 3 Supplemental sample: 3							
	Suppremental sur						
These deficiencies also reflect state							
	findings in accor	dance with 410 IAC 16.2.					
		1 . 1 . 1 . 1 . 2					
	Bartelt, RN.	pleted 4/26/11 by Jennie					
	Burten, Riv.						
F0279	A facility must use			ľ			
SS=D		velop, review and revise the hensive plan of care.					
	resident's comprei	nensive plan of care.					
	-	evelop a comprehensive					
	•	resident that includes tives and timetables to meet					
	•	al, nursing, and mental and					
	psychosocial need	ds that are identified in the					
	comprehensive as	ssessment.					
	The care plan mus	st describe the services that					
		d to attain or maintain the					
	_	practicable physical, losocial well-being as					
		83.25; and any services that					
	would otherwise b	e required under §483.25					
		ed due to the resident's under §483.10, including the					
	•	under §483.10, including the itment under §483.10(b)(4).					
ľ	Based on reco		F02	279	F279 Comprehensive Care		05/21/2011
		nd interview, the			Plans It is the practice of the		
		to ensure care was			facility to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility develops a comprehensive		
		pdated related to					
1 -	-	pressure ulcers for					
	r · · · · · · · · · · · · · · · · ·	F			care plan for each resident th		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155291 04/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3017 VALLEY FARMS ROAD **EAGLE VALLEY MEADOWS** INDIANAPOLIS, IN46214 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX COMPLETION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE includes measureable objectives residents at risk and with history of and timetables to meet a resident' pressure ulcers; dietary needs for s medical, nursing, and mental the resident at risk for nutritional and psychosocial needs that are identified in the comprehensive compromise; and psychosocial assessment. The care plan needs for the resident who refused describes the services that are to be furnished to attain or maintain needed care. The deficient practice the resident's highest practicable affected 1 resident in a sample of 3 physical, mental, and psychosocial well-being as (Resident B) and 2 residents in a required. What corrective supplemental sample of 3 reviewed action(s) will be accomplished for those residents found to have for pressure ulcers. (Residents D been affected by the deficient and E) practice? · Resident D was reassessed by a licensed nurse and a Wound Consultant. Care Findings include: plan has been updated to reflect new interventions to include Roho mattress and increase in 1. During an observation on supplements. Supplements 4/21/11 at 11:15 A.M., Resident D continue to change as the needs of the resident change. Resident was resting in bed on a scoop E's wound has healed and mattress, on her back, and the head preventative measures are in place including the utilization of of the bed was elevated 30 degrees. Roho overlay and an extra thick barrier cream. Resident's care The clinical record of Resident D plan has been updated to include new interventions i.e roho was reviewed on 4/21/11 at 9:45 cushion, extra thick barrier cream A.M. and no brief in bed. Resident B no longer resides at the facility therefore no corrective action Diagnoses for Resident D included, could be taken. How will you identify other residents having the but were not limited to, Alzheimer's potential to be affected by the dementia, diabetes, Parkinson same deficient practice and what corrective action will be taken? disease, peripheral vascular disease Residents with actual/potential for and chronic renal deficiency. skin breakdown and weight loss

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL		
		155291	B. WIN			04/21/2	U11	
NAME OF	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE			
E401E1	VALLEY MEADONA			3017 VALLEY FARMS ROAD INDIANAPOLIS, IN46214				
EAGLE	VALLEY MEADOWS			INDIAN	APOLIS, IN46214			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	, i	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION)	-	TAG	have the potential to be effect	etod	DATE	
					by the alleged deficient prac			
	A Nursing Ad	mission Assessment,			Licensed Nurses, and			
	dated 5/4/10, i	indicated Resident D			Interdisciplinary team have b			
	had "2 small r	pressure ulcers on			re-educated on identification			
	1	en admitted to the			appropriate interventions for those at risk/actual skin			
		in duffitted to the			breakdown and weight loss I	ру		
	facility.				Nurse Consultant/SDC by M			
					2011. The Interdisciplinary			
	A quarterly M	inimum Data Set			was re-educated on May 9, 3 on the care plan process by			
	(MDS) assessi	ment, dated 1/11/11,			Nurse Consultant. What			
	indicated Resi	dent D was totally			measures will be put into p	lace		
		the assistance of two			or what systemic changes			
	1 -				will make to ensure that the			
		for repositioning in			deficient practice does not recur? Residents are			
	bed and for tra				assessed upon admission,			
	incontinent of	bowel and bladder,			quarterly, annually and with			
	was at risk for	the development of			significant changes to iden	-		
	pressure ulcer	s and had no			those residents who are at	risk		
	unhealed press				for skin breakdown and nutritionally at risk.· The			
	amirearea presi	sare areers.			Interdisciplinary team will			
	A DI CC	1 / 10/10/10 1			review residents new			
		e, dated 8/10/10 and			admissions/readmissions			
	reviewed on 1	1/10/10, 1/27/11 and			during the clinical meeting			
	4/11/11, indica	ated the resident was			identify those residents at for skin breakdown and en			
	at risk for skir	n break down due to:			appropriate interventions a			
	"decreased mo	obility being			place and care planned. R			
		bowel and having a			process includes reviewing			
					resident assessments and			
		eripheral vascular			plans quarterly, annually a	nd		
		ent has end stage			with significant change. Licensed Nurses will round	l on		
	Alzheimer's d	isease with			their shift to ensure reside			
	unavoidable sl	kin break down."			plan of care is being follow			
	Interventions	included, but were			Nurse Managers will monit			
		moradoa, out were			MAR/TAR 3 x a week to en	sure		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155291	1	LDING	00	04/21/2011
		100231	B. WIN		A DDDEGG CITY GTATE ZID CODE	04/21/2011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
EAGLE \	ALLEY MEADOWS			1	APOLIS, IN46214	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)		TAG	compliance with plan of ca	-
		"Turn and reposition			Licensed nurses will ensur	
	at least every t				documentation of supplem	
	incontinent car	re as needed, assess			is documented in cc's and	
	and document	skin condition			treatment are documented	
	weekly, pressure				orderedHow the corrective action(s) will be monitored	
				ensure the deficient practic	I	
	reducing/redistribution mattress on bed, pressure				will not recur, i.e., what qua	-
	/ 1	tribution quehion in			assurance program will be	put
	reducing/redistribution cushion in chair, preventive treatment as ordered, bridge heels off bed while				into place? · A Care Plan Continuous Quality	
					Improvement tool will be	
					utililzed week x 4, monthly	x 2,
	in bed every sl	hift as a preventive."			and quarterly thereafter.	
	On 4/19/11 the	e following was			gathered will be reviewed to the CQI committee. If	py
	added to the P	lan of Care: "has			threshold is not achieved,	an
	open areas on	bilateral buttocks, tx			action plan may be develor	
	•	ordered and fortified			to include	
	` ′	w interventions were			re-education/disciplinary a to ensure compliance.Wha	
					the date by which the syste	
	• •	prevent pressure			changes will be completed	
	ulcers.				May 21, 2011	
	A Physician's	Summary, dated for				
	the month of A	April 2011, indicated				
	the resident ha	d been on super				
	cereal since 5/	_				
	Δ Dietary Pro	gress note, dated				
	,	,				
	· ·	ne noted), indicated,				
	· ·	inue) [with] Super				
	cereal in A.M.	- ensure plus 240 ml				
	(milliliters) -	[every] day. Res				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		155291	B. WIN			04/21/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
EAGLE \	ALLEY MEADOWS			1	ALLEY FARMS ROAD APOLIS, IN46214		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
-	(resident) rece	··		-			
	,	agrees to con't - no					
	_	or aggressive tx					
	_	The next Dietary					
	note was dated	1 2/11/11 and noted					
	the open area	on the buttocks was					
	healed.						
	A physician's order, dated 1/18/11,						
	indicated, "Cle	eanse area to [left]					
	buttocks [with] normal saline pat					
	dry, cover [wit	th] Allevyn [every] 3					
	days & PRN (a	as needed)"					
		1: T (IDT)					
	-	linary Team (IDT)					
		, dated 1/27/11 (no					
	· ·	idicated, "IDT review					
		ea to buttocks is					
	healed"						
	A nhysician's a	order, dated 4/19/11					
	1 1	indicated, "Allevyn to					
	•	cks q other day and					
		or dislodgement."					
	- 12. Sponuse						
	A Pressure Wo	ound Skin Evaluation					
	Report, dated	4/19/11 (not time					
	noted), indicat	,					
	*	ess loss of dermis) on					

IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION 00	i i	e survey pleted /2011
PROVIDER OR SUPPLIER		STRE 301	EET ADDRESS, CITY, STATI 7 VALLEY FARMS RO IANAPOLIS, IN46214	OAD	
SUMMARY S (EACH DEFICIEN REGULATORY OR the right buttor centimeters an left buttocks .5 centimeters. There were no regarding thes the buttocks. Information re preventive me pressure ulcers place was requ Executive Dire on 4/21/11 at 1 information w exiting the face 2. During an of 4/21/11 at 11:2 was resting in mattress, on he	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) cks .7 x .6 x < .1 d a stage II on the 5 x .5 x < .1 nursing notes e new open areas to garding any asures to avoid future s that were put in lested from the ector during interview 1:30 P.M. No as received prior to	STRE 301	7 VALLEY FARMS RO IANAPOLIS, IN46214 PROVIDER'S PLA (EACH CORRECTIVE A CROSS-REFERENCED	OAD I AN OF CORRECTION	(X5) COMPLETION DATE
	cord of Resident E on 4/21/11 at 8:45				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291		ì	LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/21/2	ETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS ROAD INDIANAPOLIS, IN46214				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Diagnoses for but were not le disease, depre disease and p disease. An annual MI indicated Resi extensive assist members to refor transfers, v bowel and bla for pressure ulta A Plan of Cardindicated, "Reskin breakdow staff for bed mincontinent of impaired mob down in bed, I peripheral vas and hypothyrocognition relations."	Resident E included, imited to, Alzheimer's ssion, Parkinson eripheral vascular OS, dated 3/9/11, dent E required the st of two staff sposition in bed and was incontinent of dder, and was at risk leers. e, dated 3/24/2011, sident is a risk for yn being dependent of			CROSS-REFERENCED TO THE APPROPRIA	TE	
	reposition at le	imited to, "Turn and east every two hours, nge every 2 hours, cument skin condition					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE S COMPL		
		155291	B. WIN			04/21/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	•	
EAGLE \	/ALLEY MEADOWS			1	ALLEY FARMS ROAD APOLIS, IN46214		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	weekly,press	· · · · · · · · · · · · · · · · · · ·					
	reducing/redistribution mattress on						
	bed, supplements as ordered and						
		n bed check every					
	shift." The Pla	•					
	updated on 4/1	9/11, "open area to					
	buttock" and the	he approaches were					
	updated to include "tx as ordered."						
	No new approaches were put in						
	place to prevent pressure ulcers.						
	· ·	dated 11/24/10,					
	indicated, "ID'	T review of wound:					
		II open area to [right]					
	buttocks"						
	A Physician's 1	Note, dated 11/30/10,					
	indicated Resi	dent E had a history					
	of an abrrated	(sic) area on the right					
	buttocks, had	ordered Allevyn on					
	11/17/10, and	the area was healed.					
	Δ Dietary Note	e, dated 3/8/11,					
	l	n't [with] puree -					
	· · · · · · · · · · · · · · · · · · ·	ectar thick liquids] et					
		0 ml BID (twice a					
		l foods - [no] noted					
	T .	t hx (history) of o/a's					
	(open areas) ne	· · · · · · · · · · · · · · · · · · ·					
	(Spen areas) in						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155291		(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE S COMPL 04/21/2	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS ROAD INDIANAPOLIS, IN46214					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE	
	indicated Resi	Note, dated 3/29/11, dent E had a on the right buttocks.						
	4/15/11, indica	n Assessment, dated ated the right nued [with] pink						
	indicated, "TX buttocks: clea	order, dated 4/19/11, I to open area on In [with] NS, apply ery] 3 days and PRN odgement."						
	dated 4/19/11,	und Skin Report, indicated a stage II on the buttock: .5 x neters.						
	There were no regarding this buttocks.	nursing notes new open area to the						
	pressure ulcers	egarding any asures to avoid future as that were put in sested from the						

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION 00	COM	TE SURVEY IPLETED 1/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS ROAD INDIANAPOLIS, IN46214				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE : CROSS-REFERENCED	AN OF CORRECTION ACTION SHOULD BE 0 TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
TAG	Executive Direction on 4/21/11 at 1 information we exiting the fact 3. The record of on 4/18/11 at 10: Diagnoses include to, acute renal fact (muscle wasting diabetes mellitus hypothyroidism, pulmonary disease, demention of the disease, demention of the disease, demention of the disease of	ector during interview 1:30 P.M. No as received prior to ility. Resident B was reviewed 30 a.m. led, but were not limited ilure, rhabdomyolysis leading to renal failure), , phlebitis, hypertension, chronic obstructive se, coronary artery a, and psychosis. num Data Set (M.D.S.) 12/20/11 indicated coor appetite, required civities of daily living ive assistance- one person or bed mobility, and assistance-one person ce for eating. and Risk Assessment" cated, "the resident is ping skin breakdown. olan with appropriate the assessment did not ent B's level of risk for	TAG	DEFIC	IENCY)	DATE	
	Pressure wounds Resident B had a	care plan for the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMP	LETED
		155291	B. WIN	G		04/21/2	2011
NAME OF I	PROVIDER OR SUPPLIE	R		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	ALLEY FARMS ROAD		
EAGLE \	ALLEY MEADOW	S		INDIAN	APOLIS, IN46214		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF	BE RIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1 ^	ential skin breakdown					
	1 ^	red mobility, being					
		owel and bladder and					
	_	r developing pressure					
		e plan had a "Problem					
	Start Date" of 2	/22/11. Approaches to this					
	problem were:						
		tion every 2 hours.					
	Offer to toilet every 2 hours.						
		re as needed using peri					
	wash and moist						
	Assess and docu	ment skin condition					
	weekly and as n	eeded. Notify MD of					
	abnormal findin	gs.					
	Encourage resid	ent to eat at least 75% of					
	meals.						
	Pressure reducir	ng/redistribution mattress					
	on bed.						
		nd written note was added					
	_	indicating "Unstageable					
	1	xcontributing factors					
	1 ^	etary intake with low					
	prealbumin, non	-					
		times." Nurse's notes					
		occyx wound to be first					
	identified on 3/2	27/11.					
	An approach wa	as added stating the name					
	of a nutritional s	supplement. There was no					
	amount of consu	umption or frequency					
	stated. There we	ere no goals, timetables, or					
		ectives, or any other	\perp				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S		
		155291	A. BUII B. WIN			04/21/2	
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
EAGLE \	/ALLEY MEADOWS			1	ALLEY FARMS ROAD APOLIS, IN46214		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
mo		the implementation for		mo			BIIIE
	address the stated being noncompli	cluded no approaches to d problem of Resident B ant with repositioning, , incontinence care, or					
	problem of "Requirelated to related	care plan with a stated uires a therapeutic diet to need for dialysis" date are plan's approaches to e:					
	within limitations Monitor weights Notify MD/Fami changes. Monitor food/flu Offer substitute i meal is consumed Educate resident	od preferences that are s of diet restriction. weekly. ly of significant weight id intake at meals. f less than 75% of any					
	indicated Resider pounds at admiss An I.D.T. (Interd	ess Note dated 2/11/11 int B's weight was 179.5 sion. disciplinary Team) Note ed a current weight of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE : COMPL		
		155291	A. BUI B. WIN			04/21/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF F	PROVIDER OR SUPPLIER			3017 VA	ALLEY FARMS ROAD		
	ALLEY MEADOWS				APOLIS, IN46214		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
1110		0.3 percent weight loss	+	1110			DITTE
	since admission.	-					
	since admission.						
	A Dietary Progre	ess Note of 3/11/11					
	indicated Reside	nt B was started on a					
	dietary suppleme	ent on $3/2/11$. There were					
	no other resident	-specific dietary					
	interventions not	ed. There were no					
	additional Dietar	y Progress notes after					
	3/11/11.						
	A physician's ord	ler dated 3/11/11					
	indicated Resider	nt B's weight was to be					
	documented before	ore and after dialysis. The					
	record contained	no documentation of					
	these weights.						
	A physician's ord	ler dated 3/4/11 indicated					
	Resident B was t						
		a dietary supplement for					
	` '	amount consumed was to					
	· ·	n the resident's record.					
		cord contained no					
		f the amount of the					
		esident consumed.					
	11						
	During an intervi	iew with the Dietary					
		19/11 at 10:25 a.m. with					
	_	t Resident B's meal					
	consumption rec	ords were reviewed. The					
	Dietary Supervis	or indicated she had					
	computed Reside	ent B's average meal					
	consumption for	the month of March to					
	be 50%. She indi	icated no changes to					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155291	B. WIN			04/21/2	011
NAME OF I	PROVIDER OR SUPPLIER	<u>I</u>	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TVI WILL OF T	NO VIDER OR BUTTELLA			I	ALLEY FARMS ROAD		
EAGLE \	ALLEY MEADOWS			INDIAN	APOLIS, IN46214		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		care plan had been made					
	_	is assessment. The					
		N.S. both agreed the					
		ent consumption had not					
		d as ordered, and that pre					
	and post dialysis	weights had not been					
	recorded.						
		ted 3/27/11 at 2:00 p.m.					
		n area found on coccyx 2					
	small openings o	n each cheek. (Symbol					
	for "right") cheel	k wound is 5 cm					
	(centimeters) x 1	.5 cm wound bed is pink					
	and clean. (Symb	ool for "left") cheek					
	wound is 3 cm x	1.3 cm wound bed is					
	yellow with black	k outer side"					
	During an intervi	iew on 4/18/11 at 1:45					
	p.m. the Assistan	t Director of Nursing					
	indicated Reside	nt B had been					
	noncompliant wi	th care, including					
	_	nt of his pressure sores,					
	I -	ence care, and refusing to					
	eat.						
	Resident B's care	e plans contained no					
	documentation o	-					
		address his refusal of					
	care.						
	Nurse's notes cor	ncerning Resident B's					
	participation in his care included:						
	1						
	3/06/11 2:00 p.m	refused to get out of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M A. BUI		NSTRUCTION 00	(X3) DATE S	ETED
		155291	B. WIN	G		04/21/2	011
	PROVIDER OR SUPPLIER		•	3017 VA	ADDRESS, CITY, STATE, ZIP CODE ALLEY FARMS ROAD		
EAGLE \	ALLEY MEADOWS			INDIAN	APOLIS, IN46214		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DETCIENCT)		DATE
	bed for breakfast						
		"Encouraged resident to e. Refuses to attempt to					
	do more with car do anything for h	•					
		"C/O (complains) he					
	can't feed himsel						
		n. "Refuses to attempt to					
		estates 'I can't'"					
		. "Requires co-ercing					
	_	e resident to do anything.					
	for himself. He s	, ,					
	3/22/11 2:00 p.m	. "always saying "I					
	can't do it, you no	eed to do everything for					
	me.'"						
	3/29/11 6:00 p.m						
	"RepositionedF	Resident refuses at					
	times"						
	3/30/11 2:00 p.m	. "Resident will wiggle					
	self back to lying						
	1	n. "Resident resistive					
	to turning"						
		. "Res has refused to					
	turn from side to						
		. "res continues to turn					
		uses to (arrow pointing					
		r "decrease") pressure on					
	coccyx area"						
	Resident R had n	o care plan problems,					
		ntions for Resident B's					
	-	s unable to help himself					
		of staff interventions, or					
		nply with interventions,					
		ning, identified for his					
	Positio						

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Event ID:

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Facility ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155291			(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMP 04/21/2	LETED
	PROVIDER OR SUPPLIEF		3017 V	ADDRESS, CITY, STATE, ZIP COE ALLEY FARMS ROAD APOLIS, IN46214	DE T	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	pressure sores. During an interval.m. the D.N.S. is known why Reside been updated to significant weight consumption of and positioning, need for additional documents. At exit on 4/21/11 additional documents.			CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	

PRINTED: 05/23/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155291			(X2) MI A. BUII B. WIN	LDING G	NSTRUCTION 00	(X3) DATE: COMPL 04/21/2	ETED
	PROVIDER OR SUPPLIER			3017 VA	ADDRESS, CITY, STATE, ZIP CODE ALLEY FARMS ROAD APOLIS, IN46214		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F0314 SS=J	a resident, the factoresident who enterpressure sores do sores unless the indemonstrates that a resident having necessary treatment healing, prevent insores from develoted Based on observation interview, the factoresident at risk for pressure ulcers dulcers. The facility implement care fulcers. The facility implement physical relief and treatment developed. The developed. The developed increased in size pressure ulcers in of 3 (Residents Indeveloped two pressure ulcers to buttocks, including Stage 3 or 4. Resewith diagnoses in ulcer, hypotension.	ation, record review and cility failed to ensure a or development of id not develop pressure ty failed to plan and for prevention of pressure ty failed to clarify and cian's orders for pressure ent when pressure ulcers defective practice affected eviewed related to a sample of 3 (Resident idents reviewed for a supplemental sample of and E). Resident B ressure ulcers, which and number to multiple of the coccyx and and wounds described as ident B was hospitalized acluding sacral decubitus on, and sepsis.	F0	314	F314 Treatment/Svcs To Prevent/heal Pressure Sore The facility is requesting an IDR for this deficiency. It is a practice of this provider base the comprehensive assessm of a resident, the facility must ensure that a resident who e the facility without pressure a does not develop pressure a unless the individual's clinical condition demonstrates that were unavoidable and a resi having pressure sores receiv necessary treatment and ser to promote healing, prevent infections and prevent new a from developing. What corre action(s) will be accomplish for those residents found to have been affected by the deficient practice? Reside was assessed by a licensed nurse and a Wound Consulta with new interventions care planned to include a Roho or and additional nutritional supplements. Supplements continue to change as the ne of the resident changes.	the ed on elent st enters sores ores electives ores ective hed or ent D ent D ent D	05/21/2011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155291 04/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3017 VALLEY FARMS ROAD **EAGLE VALLEY MEADOWS** INDIANAPOLIS, IN46214 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Resident E's wound is healed. Jeopardy was identified on 4/19/11 and Preventive interventions include a began on 3/27/11. The Director of Roho overlay, nutritional Nursing Services, the Director of Nursing supplements and an extra thick Services Specialist, and the Executive barrier cream. Care plan has Director were notified of the Immediate been updated to reflect current interventions. · Resident B no Jeopardy on 4/19/11. The Immediate longer resides at the facility Jeopardy was removed on 4/21/11, but the therefore no corrective action facility remained out of compliance at a could be taken. A skin sweep level of isolated, no actual harm with was completed at the facility to potential for more than minimal harm that aid in identifying any alterations in skin integrity 0n is not immediate jeopardy because the 4-20-2011. How will you identify facility continued to physically assess other residents having the residents for pressure sore and nutritional potential to be affected by the risks, identify appropriate interventions, same deficient practice and update care plans and nutritional what corrective action will be taken? Residents who are at assessments, and inservice all staff. risk for pressure sores have the potential to be effected by the Findings include: alleged deficient practice. Licensed Nurses and certified 1. A facility policy titled "Skin nursing assistants have been re-educated on wound Management Program," dated 1/10, prevention/interventions by the received from the Director of Nursing Nurse Consultant/SDC during the Services (D.N.S.) on 4/19/11 at 9:15 a.m., week of May 2, 2011. What measures will be put into place or and indicated to be the facility's current what systemic changes you will policy indicated: make to ensure that the deficient practice does not recur? "Policy: It is the policy of (name of the **Licensed Nurses will complete** facility's parent company) to assess each a weekly head to toe assessment on every residentresident to determine the risk of potential The certified nursing skin integrity impairment... assistants complete shower sheets on specific shower days Procedure: 2... Residents identified at risk and immediately inform the as determined by the reason(s) indicated charge nurse of any alteration in skin integrity. i.e. redness, on the assessment will be provided with

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155291		A. BUI	LDING	NSTRUCTION 00	(X3) DATE SURVE COMPLETED 04/21/2011	Y	
		100231	B. WIN		PRESIDENCE CONTROL CON	04/21/2011	
NAME OF	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE		
EAGLE	VALLEY MEADOWS	5		1	ALLEY FARMS ROAD APOLIS, IN46214		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	Έ	PLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	pressure relievin	g devices. A care plan			open areas, rashes, etc. A		
	will be develope	ed specific to the resident's			reported or assessed chan	ges	
	needs. including	prevention interventions.			in skin integrity will be		
	_	rs will be notified of the			reported to the physician a family with appropriate	10	
	resident's specifi				treatment and intervention	s in	
	1 ^	ressure reduction devices			place. Resident's plan of c		
					will be updated to reflect		
		place immediatelyThe			current interventions.		
		vill notify the wound nurse			Charge nurse and nurse		
	1	s in skin integrity. The			managers are rounding at a	ı	
	facility assigned	wound nurse will			minimum of 3 x per shift to		
	complete a furth	er evaluation of wounds			ensure interventions are in		
	identified. The c	are plan will be			place per plan of care. ·		
	initiated/revised	addressing any new			Interdisciplinary team revi		
		e givers will be notified			physician orders and chang		
		ns and specific care			in condition during morning	9	
	instructions."	is and specific care			meetings.· A wound nurse/designee is assigned	.	
	ilistructions.				the facility and completes	"	
					wound rounds with the		
	1	titled "IDT Review of			interdisciplinary team on a		
	Residents with V	Weight and Nutritional			weekly basis. · Wound		
	Concerns, dated	1/10, received from the			Consultant will round week	ly	
	D.N.S. on 4/19/1	11 at 9:15 a.m., and			on wound rounds and make	- 1	
	indicated to be the	he facility's current policy			recommendations as		
	indicated:	1 2			appropriate in progress no	I	
					Progress notes are reviewed	d	
	"Residents to res	view:Residents			with wound nurse. The		
		g weight prior to			Interdisciplinary team revie		
	1 ^				wound round documentation from wound nurse and wou		
		t loss. Residents with			consultant and develops	"	
	significant weigh	nt ioss.			appropriate interventions		
					based upon progress/regre	ss	
	Initial IDT note	documentation or			of the wound. The		
	residents with w	eight loss or nutritional			Interdisciplinary team		
	concernsRisk	factors for the weight loss			documents weekly in each		
	to include but no	· ·			individual resident medical		
		edications, (3) Relevant			record. The wound nurse	will	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155291		A. BUI	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/21/2011	
NAME OF	PROVIDER OR SUPPLIER		B. WIN		ADDRESS, CITY, STATE, ZIP CODE	04/21/2011
NAME OF	PROVIDER OR SUPPLIER	X.		1	ALLEY FARMS ROAD	
EAGLE \	VALLEY MEADOWS	3		INDIAN	APOLIS, IN46214	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	,	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
IAG	†	4) behaviors and (why the	+	IAG	audit shower sheets and	DATE
	· ·	occurredInterventions			weekly skin assessments for	or
		to the resident include but			alteration with skin integrit	y.·
	1	o: (1) calorie dense foods,			MAR/TAR audit will be	
		s during bests meals and			conducted 3 x week to enside documentation of supplementation	I
		if food items are ruled			are documented in cc's and	
		sineticsUpdates to nurse			treatments are completed a	
	. ,	lates to care plans			ordered Residents' plans	
	1	ible resident input and			care and assignment sheet	I
	preferences.	1			are updated during morning meeting and communicated	- I
					the direct care staffHow the	
	Follow up IDT n	otes if not gaining			corrective action(s) will be	
	weight:New in	terventions specific to			monitored to ensure the	
	each residentU	pdate to care plans			deficient practice will not re i.e., what quality assurance	· ·
	including if poss	ible resident input and			program will be put into pla	I
	preferences and	whether the resident or			· Quality Improvement too	
	family were able	to participate in the care			will be utilized weekly x 4,	
	plan."				monthly x 2 and quarterly thereafter to ensure	
					compliance. Data gathere	d l
	2. The record of	Resident B was reviewed			will be reviewed by the CQI	
	on 4/18/11 at 10	:30 a.m.			committee and action plans	
					will be developed if thresholds is not achieved. Licensed	old
	"	ded, but were not limited			nurses and CNAs will be	
	1	ilure, rhabdomyolysis			reeducated on wound	
	`	leading to renal failure),			prevention no less than	
	1	s, phlebitis, hypertension,			quarterly by Staff Developm	I
	1 ** *	chronic obstructive			coordinator. Pressure ulce prevention will be reviewed	
	1 *	se, coronary artery			during orientation program	
	disease, dementi	a, and psychosis.			with licensed nurses and	
	Am Initial Minim	Doto Cot (M.D.C.)			CNAs What is the date by	
		num Data Set (M.D.S.)			which the systemic change will be completed? May 21,	
		d 2/20/11, which			will be completed fillay 21,	2011
		nt B had poor appetite,				
	required assistan	ce for activities of daily				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155291		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/21/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEI	!! {		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
EAGLE \	VALLEY MEADOWS	5		1	ALLEY FARMS ROAD APOLIS, IN46214		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	†	extensive assistance- one		TAG	DEFICIENC!)		DATE
	1	assist for bed mobility,					
		ted assistance-one person					
	physical assistar	ace for eating.					
	A "Nursing Adm	nission Assessment" for					
	Resident B, date	d 2/9/11, indicated the					
	1	pressure sores on					
	admission to the	facility.					
	A "Pressure Wou	and Risk Assessment,"					
	dated 2/9/11, inc	licated, "the resident is					
		oping skin breakdown.					
	1	plan with appropriate					
		The assessment did not ent B's level of risk for					
	pressure wounds						
	Resident B had a	a care plan for the					
	1 ^	ential skin breakdown					
		red mobility, being owel and bladder and					
		developing pressure					
	_	e plan had a "Problem					
	Start Date" of 2/	22/11. Approaches to this					
	problem were:						
	Turn and reposit	ion every 2 hours.					
	Offer to toilet ev	-					
		re as needed using peri					
	wash and moisture barrier.						
	Assess and document skin condition weekly and as needed. Notify MD of						
	abnormal finding	-					

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AND PLAN	OF CORRECTION	155291	A. BUI	LDING	00	04/21/2	
		155291	B. WIN			04/21/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
FAGLE \	ALLEY MEADOWS			1	ALLEY FARMS ROAD APOLIS, IN46214		
			-		711 0210, 11110211		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		ent to eat at least 75% of	•				
	meals.						
		g/redistribution mattress					
	on bed.	5					
	An undated, hand	d written note was added					
		indicating "Unstageable					
		contributing factors					
		tary intake with low					
	prealbumin, none	•					
	repositioning at t	-					
	An approach was	s added stating the name					
		applement. There was no					
		ency stated. There were					
	_	les, or measurable					
	objectives for thi						
	ĺ	11					
	The care plan inc	cluded no approaches to					
	_	d problem of Resident B					
	being noncompli	ant with repositioning.					
	Resident B's "We	eekly Skin Assessment"					
	sheets indicated:						
	2/18/11: No cond	eerns.					
	2/25/11: Skin tea	r on left knee					
	3/05/22: No cond	erns.					
	3/11/11: Subclav	ian port, site intact.					
	3/18/11: No cond	eerns.					
	3/25/11: No concerns.						
	4/01/11: Open area to coccyx-odor noted.						
	Yellow eschar no	ted.					
	4/11/11: (Symbo	l for "increased") Fluids					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155291	B. WIN			04/21/20)11
NAME OF I	PROVIDER OR SUPPLIER	<u>I</u>	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	ROVIDER OR SOLI EIER			1	ALLEY FARMS ROAD		
EAGLE \	ALLEY MEADOWS			INDIAN	APOLIS, IN46214		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	I -	(treatment) to coccyx					
	` ′	area (symbol for					
	"with") dark cent	ter-white edges-					
	increased odor						
		ess Note, dated 2/11/11,					
		nt B's weight was 179.5					
	pounds at admiss	sion.					
	An IDT (Int. 1	linain linama Tanus Nista					
	· ·	lisciplinary Team) Note					
		ed a current weight of					
		0.3 percent weight loss					
	since admission.						
	During on intervi	ion with the Dietory					
	· -	iew with the Dietary					
	1 ^	19/11 at 10:25 a.m.					
		al consumption records					
		The Dietary Supervisor					
		l computed Resident B's					
		nsumption for the month					
	of March to be 5	0%.					
	A Dietory Progra	ess Note of 3/11/11					
	1	nt B was started on a					
	1 - 11	ent on 3/2/11. There were					
	no other resident	-					
		red. There were no					
	additional Dietary Progress notes after						
	3/11/11.						
	A physician's order deted 2/11/11						
	A physician's order, dated 3/11/11,						
	indicated Resident B's weight was to be documented before and after dialysis. The						
	record contained	no documentation of					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ľ		ONSTRUCTION 00	(X3) DATE : COMPL	
		155291	A. BUI			04/21/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1	ALLEY FARMS ROAD		
	ALLEY MEADOWS			1	APOLIS, IN46214		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	these weights.						
		1 1 2 4 4 4 4 4					
	A physician's ord						
		nt B was to receive 60 ml					
		a dietary supplement for					
		amount consumed was to					
		n the resident's record.					
		cord contained no					
		f the amount of the					
	supplement the re	esident consumed.					
		se's notes from admission					
	on 2/09/11 throug	gh 3/26/11 found no					
	documentation of	f any skin care issues or					
	concerns. There	was no documentation of					
	any turning or re	positioning in the nurse's					
	notes during this	period.					
	A nurse's note, da	ated 3/27/11 at 2:00 p.m.,					
	indicated, "ope	n area found on coccyx 2					
	small openings o	n each cheek. (Symbol					
	for "right") cheel	wound is 5 cm					
	(centimeters) x 1	.5 cm wound bed is pink					
	and clean. (Symb	ool for "left") cheek					
	wound is 3 cm x	1.3 cm wound bed is					
	yellow with black	k outer side"					
	During an intervi	iew on 4/18/11 at 1:45					
	_	t Director of Nursing					
	-	nt B was noncompliant					
		ing refusing treatment of					
		s, refusing incontinence					
	care, and refusing	_					
		D 					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUII		INSTRUCTION 00	(X3) DATE COMPL	
		155291	B. WIN			04/21/2	011
	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE ALLEY FARMS ROAD APOLIS, IN46214		
					APOLIS, IN40214		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Resident B's care plans contained no documentation of any plan or interventions to address his refusal of care.						
	Nurse's notes concerning Resident B's participation in his care included:						
	3/06/11 2:00 p.m. "refused to get out of bed for breakfast" 3/07/11 2:00 p.m. "Encouraged resident to do more with care. Refuses to attempt to do anything for himself." 3/08/11 2:00 p.m. "C/O (complains) he						
	can't feed himsel 3/09/11 11:00 a.r. to assist with card 3/21/11 2:00 p.m						
	for himself. He states 'I can't'" 3/22/11 2:00 p.m. "always saying "I can't do it, you need to do everything for me."						
	3/29/11 6:00 p.m. "RepositionedResident refuses at times" 3/30/11 2:00 p.m. "Resident will wiggle						
	to turning"	m. "Resident resistive					
	turn from side to 4/05/11 3:00 a.m	. "Res has refused to side" . "res continues to turn uses to (arrow pointing					

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Event ID:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155291		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMP 04/21/2	LETED	
	PROVIDER OR SUPPLIEF		3017 V	ADDRESS, CITY, STATE, ZIP COD ALLEY FARMS ROAD APOLIS, IN46214	Е	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	down, symbol for coccyx area"	r "decrease") pressure on				
	goals, or intervers statements he was and was in need his refusal to con	no care plan problems, ntions for Resident B's as unable to help himself of staff interventions, or imply with interventions, oning, identified for his				
	a.m. the Director indicated Reside density foam ma	iew on 4/19/11 at 10:45 of Nursing Services nt B had been on a high ttress, the standard for all facility, throughout his				
	3/27/11 at 2:00 p wound on coccy (normal saline) p of an enzymatic left sided wound cover with dry d not contain a fre	ephone order order, dated o.m., indicated, "Cleanse x (symbol for "with") NS out dry apply (trade name debriding ointment) to bed cover with 2 x 2 ressing". The order did quency for this treatment. Then done, was done on a				
	Report," dated 3 B had a Stage 1 right and left but	nd Skin Evaluation /27/11, indicated Resident pressure sore on both his tocks, with the left neasuring 5.0 by 1.5				

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE : COMPL	
		155291	B. WIN			04/21/2	011
	PROVIDER OR SUPPLIER		•	3017 VA	ADDRESS, CITY, STATE, ZIP CODE ALLEY FARMS ROAD APOLIS, IN46214	•	
					711 OLIO, 11440214		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	JΈ	DATE
	centimeters, and 1.3 centimeters.	the left measuring 3.0 by					
	_	iew with the facility's					
		on's Director of Clinical					
		/11 at 11:30 a.m., she					
		sed on the documentation					
	•	pressure sores on 3/27/11 pressure sore on Resident					
		should have been					
		age 2, and the pressure					
		uttock should have been					
	identified as Uns						
	A "Pressure Wou	nd Skin Evaluation					
	Report," dated 4/	1/11, indicated Resident					
	B had a Stage 5 ((unstageable) pressure					
	sore on both his i	right and left buttocks,					
	with the left butto	ock wound measuring 4.0					
		rs, and the left measuring					
	4.0 by 6.0 centim	neters.					
		inistration Records did					
		s treatment being done					
	on 3/28/11, 3/30/ 4/10/11.	/11, 4/2/11, 4/9/11, or					
	A physician's ord	lar datad 4/8/11					
		use Waffle Mattress until					
		an air mattress) is					
	,	ecord contained no					
		f either mattress being					
	used.						

	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MULTI A. BUILDIN B. WING		NSTRUCTION 00	(X3) DATE S COMPL 04/21/2	ETED
	PROVIDER OR SUPPLIER		30	017 VA	DDRESS, CITY, STATE, ZIP CODE LLEY FARMS ROAD APOLIS, IN46214	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	A nurse's note, dindicated, "Res. several pink/purp non-blanchable a and (arrow point Areas have appearinguries. Left low buttock: 3 x 3 cm cm, yellow in co 10 cm, left lower pink/purple areas Res. also noted to (temperature) 10 arm). M.D. notified send res. to ER (Hospital records evaluated in the 4/11/11, and adm 4/12/11. Admitting decubitus ulcers A hospital Admissinguitation of the wife and the Facility). Since he care hospital) on progressively deciple ambulatory bed being ambulatory bed bound with our urinary incontines status has dimining has lost 20 lbs. in	ated 4/11/11 at 8:15 p.m., (resident) noted to have ole discolorations, areas on left buttocks, hip ed down) lower back. Arance of deep tissue are buttock: 4 x .5 cm, left in, left front of hip: 1 x 8 dor, left posterior hip: 9 x in hip: 7 x 11 cm. Multiple is across lower left back. To be warm to the touch, To 3.1 axillary (under the fied and order received to emergency room)." indicate Resident B was emergency room on atted to the hospital on and diagnoses included and severe sepsis. It is discharge from (acute 2/9, the patient has belined in status from a with assistance to being decubitus ulcers and and per the ECF he in the last month. He has allity to feed himself. Over					

	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/21/2011
	PROVIDER OR SUPPLIER		3017 V	ADDRESS, CITY, STATE, ZIP CODE ALLEY FARMS ROAD	
EAGLE \	ALLEY MEADOWS	5	INDIAN	IAPOLIS, IN46214	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE COMPLETION
		has had more significant ast 3 days, he has had ay as well."			
	A hospital Disch indicated:	arge Note, dated 4/20/11,			
	"Admission diag	_			
		oses: Septic shock, Sacral			
	pressure ulcers,				
	maddomyiosis, c	diabetes mellitus			
		oryHe was also found to decubitus ulcers with			
		base. He has undergone			
	1 -	orsening decline in mental			
	and physical stat	us, developing decubitus			
	ulcers, a UTI, los	ss of 20 lbs., and inability			
		Sacral pressure ulcers:			
		tage 3-4, unable to stage			
	1	to debrisPt. on air bed			
		rning and BID (twice a nges. Plastic surgery was			
	consulted 4/18, r	0 ,			
	· ·	lse lavage daily and			
	1	cer with moist-to-dry			
	dressings twice p	per dayverified need for			
	regular, aggressi	ve wound care"			
	3 During an ob	servation, on 4/21/11 at			
	_	ident D was resting in			
		mattress, on her back and			
	_	ed was elevated 30			
	degrees.				

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MUL' A. BUILD! B. WING		00	(X3) DATE S COMPL 04/21/2	ETED
	PROVIDER OR SUPPLIER			3017 VA	DDRESS, CITY, STATE, ZIP CODE LLLEY FARMS ROAD APOLIS, IN46214		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	The clinical recoreviewed on 4/2. Diagnoses for Rowere not limited Dementia, diaber peripheral vascurenal deficiency. An Nursing Adm 5/4/10, indicated	rd of Resident D was 1/11 at 9:45 A.M. esident D included, but to, Alzheimer's tes, Parkinson disease, lar disease and chronic					
	A quarterly Mini assessment, date Resident D was assistance of two repositioning in Was incontinent was at risk for the	mum Data Set (MDS) d 1/11/11, indicated totally dependent on the staff members for bed and for transfers. of bowel and bladder, e development of nd had no unhealed					
	indicated, "Clear [with] normal sa Allevyn [every] needed)" An interdisciplin Note, dated 1/27	der, dated 1/18/11, dise area to [left] buttocks line pat dry, cover [with] disays & PRN (as ary Team (IDT) Progress disays (11 (no time noted), disays (12 text)					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MULTIPI A. BUILDING B. WING	E CONSTRU 00	CTION	(X3) DATE COMPI 04/21/2	ETED
	PROVIDER OR SUPPLIER		STR 301	7 VALLEY	SS, CITY, STATE, ZIP CODE ' FARMS ROAD IS, IN46214		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CRO	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BI ISS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
1710	buttocks is heale	<u> </u>	mo				D.M.E.
	reviewed on 11/1 4/11/11, indicate for skin break do mobility, being in having a diagnos disease. Resident Alzheimer's disea break down. Inte were not limited least every two have needed, assess condition weekly reducing/redistril pressure reducing in chair, prever ordered, bridge havery shift as a p following was ach has open areas on (treatment) as ord cereal." No new place to prevent p A Physicians' ord A.M., indicated, buttocks q other dislodgement." A Pressure Wour	ase with unavoidable skin rventions included, but to: Turn and reposition at ours, incontinent care as and document skin 7, pressure bution mattress on bed, g/redistribution cushion ntive treatment as neels off bed while in bed reventive. On 4/19/11 the lded to the Plan of care: In bilateral buttocks, tx dered and fortified interventions were put in					
	•	II on the right buttocks .7					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
ANDILAN	or connection	155291	A. BUILDII		00	04/21/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ALLEY FARMS ROAD		
EAGLE \	ALLEY MEADOWS			INDIAN	APOLIS, IN46214		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		eters and a stage II on the					
		.5 x < .1 centimeters. No					
	drainage.						
		ursing notes regarding					
	tnese new open a	areas to the buttocks.					
	4. During an obs	servation, on 4/21/11 at					
	_	sident E was resting in					
	bed on a scoop n	nattress, on her left side					
		he bed was elevated 20					
	degrees.						
	The clinical reco	rd of Resident E was					
		/11 at 8: 45 A.M.					
	"	esident E included, but					
		to, Alzheimer's disease,					
	peripheral vascul	inson disease and					
	peripheral vascui	iai discase.					
	An Annual MDS	, dated 3/9/11, indicated					
		red the extensive assist of					
		rs to reposition in bed					
	· ·	was incontinent of					
		er, and was at risk for					
	pressure ulcers.						
	An IDT note, dat	ted 11/24/10, indicated,					
	l '	vound: Res has Stage II					
	open area to [rigl	nt] buttocks.					
	A Dia di Cara	4. 1.4. 1.11/20/10					
	· -	ote, dated 11/30/10, nt E had a history of an					
	mulcaled Reside	in is nau a msiory or an					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155201			ULTIPLE CO LDING	NSTRUCTION 00	COMPL	ETED	
		155291	B. WIN			04/21/2	011
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
EAGLE \	ALLEY MEADOWS	3		1	ALLEY FARMS ROAD APOLIS, IN46214		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG		,	+	TAG	DEFICIENCT)		DATE
		the right buttocks, had					
	was healed.	on 11/17/10 and the area					
	was nealed.						
	A Dietary Note	dated 3/8/11, indicated,					
		ree -[with] NTL [nectar					
		and] 2-cal 120 ml BID					
		ortified foods - [no] noted					
		x (history) of o/a's (open					
	areas) noted"						
	ŕ						
	A Plan of Care, of	dated 3/24/2011,					
	indicated, "Resid	lent is a risk for skin					
	breakdown being	g dependent of staff for					
	bed mobility, be	ing incontinent of bowel					
	and bladder, imp	paired mobility, resident					
	slides down in b	ed, having diagnoses of					
		lar disease, anemia, and					
		and impaired cognition					
	related to Alzhei						
		uded, but were not					
	Í .	and reposition at least					
		check and change every					
	-	nd document skin					
	condition weekly	•					
	_	bution mattress on bed,					
		ordered and elevate heels					
		ery shift." The Plan of d on 4/19/11, "open area					
	•	ne approaches were					
		de "tx as ordered." No					
	•	were put in place to					
	prevent pressure						
	provent prossure	W					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER					INSTRUCTION 00	(X3) DATE S COMPL	
		155291	A. BUII B. WIN			04/21/2	011
NAME OF F	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE		
EAGLE V	/ALLEY MEADOWS	i			ALLEY FARMS ROAD APOLIS, IN46214		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		te, dated 3/29/11,					
	indicated Resider the right buttocks	nt E had a redden area on					
	the right buttocks	5.					
		assessment, dated					
	,	d the right buttocks pink colored area.					
	continues [with]	print corored area.					
		der, dated 4/19/11,					
	· ·	o open area on buttocks: apply Allevyn q [every]					
		soiling or dislodgement."					
	A Pressure woun	d Skin Report, dated					
		d a stage II pressure ulcer					
	on the buttock: . No drainage.	$5 \times .4 \times < .1$ centimeters.					
		ursing notes regarding ea to the buttocks.					
	Information rega	rding any preventive					
	measures to avoi	d future pressure ulcers					
		place was requested from rector on 4/21/11 at 1:30					
		ation was received prior					
	to exiting the fac	ility.					
	During an intervi	iew with the Executive					
	Director, on 4/22	1/11 at 1:30 P.M., she					
	indicated there w in the facility.	vas no air mattress in use					
	in the facility.						

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/21/2011
NAME OF	PROVIDER OR SUPPLIEF	<u>"</u> {		ADDRESS, CITY, STATE, ZIP CODE	•
EAGLE \	ALLEY MEADOWS	6	l l	/ALLEY FARMS ROAD NAPOLIS, IN46214	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
IAG		opardy was identifed on	IAG		DAIL
		.m. The Immediatie			
	· ·	n 3/27/11 when tihe			
		ensure a residenti ati risk			
	•	of pressure ulcers did			
	· ·	sure ulcers failed tio			
	plan and impleme	enti care for prevention			
	of pressure ulcers	, and failed tio clarify			
	and implementi p	hysicians orders for			
	pressure relief and	d tireatimenti when			
	pressure ulcers de	eveloped. The Directior			
	of Nursing Service	es, tihe Directior of			
	Nursing Services S	Specialisti and tihe			
	Executive Direction	r were notifed on			
	4/19/11 ati3:20 p	.m. of tihe Immediatie			
	Jeopardy relatied	care and services for			
	pressure ulcer pre	evention and tireatimenti			
	The Immediatie Je	eopardy was removed			
	on 4/21/11 ati4:5	0 p.m. when tihrough			
	observations, inti	erview, and record			
	reviews, iti was de	etiermined tihe facilitiy			
	had implementied	d tihe plan of action tio			
	remove tihe Imme	ediatie Jeopardy and tihati			
	tihe stieps tiaken	removed tihe immediacy			
	· ·	Residenti assessmentis			
		enti records by tihe			
	1 1	orrection for discovered			
		ployee inservices were			
		ntis witih pressure sores			
		assess tireatimenti and			
		hough tihe facilitiys			
	corrective action	removed tihe Immediatie			
				1	

l	OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MULTIPLE C A. BUILDING B. WING	00 	COMP 04/21/2	LETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS ROAD INDIANAPOLIS, IN46214					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	compliance ati rec severitiy level of i witih potiential for harm tihati is noti	litiy remained outi of duced scope and solatiedno actiual harm more tihan minimal immediatie jeopardy relates to Complaint						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291			(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/21/2	ETED
	PROVIDER OR SUPPLIER			3017 VA	ADDRESS, CITY, STATE, ZIP CODE ALLEY FARMS ROAD APOLIS, IN46214		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0325 SS=J	assessment, the faresident - (1) Maintains accenutritional status, sprotein levels, unle condition demonst possible; and (2) Receives a the anutritional proble Based on record facility failed to a for weight loss at the an utrition prevent significates assessing nutrition prevent significates assessing nutrition prevent intakes physician, not respected requests from staff, and not dietary care plantaffected 1 of 6 reto weight loss and sample of 3 and a 3. (Resident B). It is significant weight hospitalized with sacral decubitus sepsis. This deficient pradimediate Jeoparation of the significant weight hospitalized with sacral decubitus sepsis.	review and interview, the ensure a resident at risk and not maintaining ional level received nal interventions to not weight loss by not an eeds in a timely ng nutritional e as ordered by the sponding to the resident's for additional assistance of updating the resident's. This deficient practice sidents reviewed related do nutritional status in a supplemental sample of Resident B developed at loss. The resident was diagnoses including alcer, hypotension, and	F0	325	F325 Maintain Nutrition State unless unavoidable The fact is requesting an IDR for this deficiency. It is the practice of this facility based on a reside comprehensive assessment facility must ensure that a resident maintains acceptabe parameters of nutritional states such as body weight and proceed levels, unless the resident's clinical condition demonstrate that this is not possible; and receives a therapeutic diet withere is a nutritional problem. What corrective action(s) we be accomplished for those residents found to have be affected by the deficient practice? Resident B no loo residents at the facility there no corrective action can be taken. Nursing staff were reeducated to the delivery and documentation of meal service and between meal nourishme food and fluid intake record and bedtime snack by the SDC of May 6, 2011 How will you identicated to be affected by the potential to be affected by the	sility s of ent's the detus, otein es when dill en nger fore ents, and on intify	05/21/2011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155291	B. WIN	G		04/21/2	011
NAME OF PROVIDER OR SUPPLIER			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	FROVIDER OR SUFFLIER			3017 VA	ALLEY FARMS ROAD		
	VALLEY MEADOWS			L	APOLIS, IN46214		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	-	TAG	•		DATE
	1 ~	1. The Director of			same deficient practice and corrective action will be take		
	Nursing Services	s, the Director of Nursing			Residents with risk factors for		
	Services Special	ist, and the Executive			poor nutritional status have		
	Director were no	otified of the Immediate			potential to be affected by th		
	Jeopardy on 4/19	9/11. The Immediate			same deficient practice. Nu	ırsing	
		moved on 4/21/11, but the			staff were re-educated t the		
		d out of compliance at a			delivery and documentation		
	1 *	no actual harm with			meal service and between m		
	1	re than minimal harm that			nourishments, food, fluid into record and bedtime snack by		
	1 ^				SDC on May 6, 2011.What	,	
		jeopardy because the			measures will be put into pla	ce or	
	_ ·	d to physically assess			what systemic changes you		
	residents for pres	ssure sore and nutritional			make to ensure that the defi	cient	
	risks, identify ap	propriate interventions,			practice does not recur-		
	update care plan	s and nutritional			Residents will be assessed f		
	assessments, and	l inservice all staff.			food preferences upon admi and with changes in conditio		
	,				Weights are obtained no less		
	Findings include	••			than monthly on all residents		
	i mamga maraac	•			Residents with significant we		
	1. A facility poli	av titlad "Slain			loss will be reassessed for d	ietary	
		- -			preferences by dietary mana	iger·	
	_	ogram," dated 1/10,			Nursing staff was provided		
		e Director of Nursing			reeducation regarding provid		
	`	.) on 4/19/11 at 9:15 a.m.,			substitutes when less than 7 of a meal is eaten. Nursing		
	and indicated to	be the facility's current			was re-educated on resident		
	policy indicated:				preferences and documenta		
					regarding percent of consum		
	"Policy: It is the	policy of (name of the			by the staff development		
	1 *	company) to assess each			coordinator on May 6, 2011		
	1 .	mine the risk of potential			Re-education/disciplinary ac		
					will be given for non-complia		
	skin integrity im	рантеш			with the facility procedureWh the date by which the system		
					changes will be completed N		
		Residents identified at risk			21, 2011 How will the correct		
	as determined by the reason(s) indicated				action(s) be monitored to en		
	on the assessmen	nt will be provided with			the deficient practice will not		
	pressure relievin	g devices. A care plan			recur, i.e. what quality assur	ance	

000188

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155291	1	LDING	00	04/21/20	
		155251	B. WIN		DDDEGG GITTY GTATE TIN GODE	04/21/20	311
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ALLEY FARMS ROAD		
EAGLE \	/ALLEY MEADOWS	;		1	APOLIS, IN46214		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	program will be put into place	2	DATE
	1	d specific to the resident's			The administrator/designee		
		prevention interventions.			monitor for compliance.		
	_	s will be notified of the			A Significant Weight Change		
	resident's specific	•			tool will be completed weekly	/ x4,	
		ressure reduction devices			monthly x2 and quarterly thereafter.		
		lace immediatelyThe			Identified issues will be subn	nitted	
		ill notify the wound nurse			to the CQI Committee for rev	view	
	1 *	s in skin integrity. The			and follow up. Re-education/disciplinary ac	tion	
		wound nurse will			will be given for non-complia		
		er evaluation of wounds			with facility procedures.What		
	identified. The ca	_			the date by which the system		
		addressing any new			changes will be completed?	May	
		e givers will be notified			21, 2011		
		s and specific care					
	instructions."						
	A facility policy	titled "IDT Review of					
		Veight and Nutritional					
		1 1/10, received from the					
	· ·	1 at 9:15 a.m., and					
		ne facility's current policy					
	indicated:	ie idenity s'editent poney					
	marourou.						
	"Residents to rev	riew:Residents					
	anticipated losing	g weight prior to					
		t loss. Residents with					
	significant weigh						
	Initial IDT note of	documentation or					
	residents with we	eight loss or nutritional					
	concernsRisk factors for the weight loss						
	to include but no	t limited to: (1)					
	diagnosis, (2) Me	edications, (3) Relevant					
	lab results and (4) behaviors and (why the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155291		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMP: 04/21/2	LETED	
	PROVIDER OR SUPPLIE		3017 V	ADDRESS, CITY, STATE, ZIP COI ALLEY FARMS ROAD IAPOLIS, IN46214	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	weight loss has of that are specific are not limited to (2) large portion (3) supplements out. (4) Pharmolaide sheetsUpoincluding if possipreferences. Follow up IDT reweight:New in each residentUpoincluding if possipreferences and family were ableighan." A facility policy Assessment," dathe Executive Do 11:00 a.m., and facility's current "Policy: The Nu will be complete change in conditioning in conditioning in the and in the care problems of the policy in the and in the care problems of the policy in the and in the care problems of the policy in the policy i	beccurredInterventions to the resident include but be (1) calorie dense foods, s during bests meals and if food items are ruled kineticsUpdates to nurse dates to care plans dible resident input and motes if not gaining terventions specific to dipdate to care plans dible resident input and whether the resident or to participate in the care titled "Nutrition Risk ted 5/06, received from frector on 4/21/11 at indicated to be the policy indicated: trition Risk Assessment adwith each significant ionIf the resident is DERATE or HIGH RISK or, follow the appropriate entions developed and nutrition progress notes				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155291	B. WIN			04/21/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L		l	ALLEY FARMS ROAD		
 FAGLE \	ALLEY MEADOWS			l	APOLIS, IN46214		
					711 0210, 11110211		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	-	IAU			DATE
	, , ,	that should be made in					
	1 -	o aid the resident in					
		tritional needs. Are the					
	care plan goals b	eing met? Do not expect					
	a change to occu	r (i.e. weight gain/loss)					
	without a change	e in the approaches"					
	2. The record of	Resident B was reviewed					
	on 4/18/11 at 10:	30 a.m.					
	Diagnoses includ	led, but were not limited					
	ı ~	ilure, rhabdomyolysis					
	I	leading to renal failure),					
	l `	,,					
		, phlebitis, hypertension,					
	1	chronic obstructive					
	1 -	se, coronary artery					
	disease, dementi	a, and psychosis.					
	An Initial Minim	num Data Set (M.D.S.)					
	assessment, date	d 2/20/11, which					
	indicated Reside	nt B had poor appetite,					
	required assistan	ce for activities of daily					
	1 ^	extensive assistance- one					
	1 ~ ~	assist for bed mobility,					
	1 1 1	ed assistance-one person					
	physical assistan	-					
	Pilybioui ubbibuii	co for outing.					
	Resident Dia Nut	rition Risk Assessment					
	1	day of admission,					
		nt B had a Nutrition Risk					
		e of 7, with 3-7 being					
		8 or greater being "high					
	risk."						

PRINTED: 05/23/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	155291	A. BUII		00	04/21/2	
		100201	B. WIN		DDDESS CITY STATE ZID CODE	04/21/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE ALLEY FARMS ROAD		
EAGLE \	/ALLEY MEADOWS			1	APOLIS, IN46214		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)		IAG	DEFICIENCE!)		DATE
	Resident B's record contained no other Nutrition Risk Assessment. This was						
		Executive Director					
	l -	on 4/21/11 at 11:30 a.m.					
	during interview	011 4 /21/11 at 11.50 a.m.					
	Resident B had a	care plan with a stated					
	problem of "Req	uires a therapeutic diet					
	related to related	to need for dialysis" date					
	2/22/2011. The c	are plan's approaches to					
	this problem wer	e:					
	D :1 1:4	MD 1					
	Provide diet per						
		od preferences that are					
		s of diet restriction.					
	Monitor weights	_					
	changes.	ly of significant weight					
	~	id intake at meals.					
		f less than 75% of any					
	meal is consume						
		on importance of diet					
		irect if possible to accept					
	diet plan.	1					
	A Dietary Progre	ess Note, dated 2/11/11,					
		nt B's weight was 179.5					
	pounds at admiss	sion.					
	An I D.T. (Inter-	ligainlinary Toom) Note					
		lisciplinary Team) Note ed a current weight of					
		_					
	161 pounds, a 10.3 percent weight loss since admission.						
	since admission.						
	A Dietary Progre	ess Note of 3/11/11					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4DO911

Facility ID:

000188 If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
		155291	B. WIN	G		04/21/20)11
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	ALLEY FARMS ROAD		
EAGLE \	/ALLEY MEADOWS			INDIAN	APOLIS, IN46214		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		nt B was started on a					
		ent on 3/2/11. There were					
	no other resident						
		ed. There were no					
		y Progress notes after					
	3/11/11.						
	A physician's and	ler, dated 3/11/11,					
	1	nt B's weight was to be					
		ore and after dialysis. The					
		no documentation of					
	these weights.	no documentation of					
	these weights.						
	A physician's ord	ler_dated 3/4/11					
	1 ^ *	nt B was to receive 60 ml					
		a dietary supplement for					
	l '	amount consumed was to					
	· ·	n the resident's record.					
		cord contained no					
		f the amount of the					
		esident consumed.					
	_ spp.oon the I						
	During an intervi	iew with the Dietary					
		19/11 at 10:25 a.m., with					
	1 ^	t, Resident B's meal					
	_	ords were reviewed. The					
	_	or indicated she had					
		ent B's average meal					
		the month of March to					
	be 50%. She indicated no changes to						
		care plan had been made					
	in response to this assessment. The						
		N.S. both agreed the					
		ent consumption had not					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155291	B. WING			04/21/2	011
		1	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					ALLEY FARMS ROAD		
EAGLE \	VALLEY MEADOWS	3			APOLIS, IN46214		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		d as ordered, and that pre					
	1 1	weights had not been					
	recorded.						
	_	iew on 4/18/11 at 1:45					
	p.m. the Assistar	nt Director of Nursing					
	indicated resider	nt B was noncompliant					
	with care, include	ling refusing treatment of					
	his pressure sore	es, refusing incontinence					
	care, and refusin	g to eat.					
	Resident B's care	e plans contained no					
	documentation of	-					
	interventions to	address his refusal of					
	care.						
	Nurse's notes co	ncerning Resident B's					
	participation in l	nis care included:					
	3/06/11 2:00 p.n	n. "refused to get out of					
	bed for breakfas						
	3/07/11 2:00 p.m	n."Encouraged resident to					
	1	re. Refuses to attempt to					
	do anything for l	•					
		n. "C/O (complains) he					
	can't feed himse						
		m. "Refuses to attempt to					
		estates 'I can't'"					
		n. "Requires co-ercing					
	_	ge resident to do anything.					
	for himself. He s	, , ,					
		n. "always saying "I					
	_	· · · · ·					
	I -	eed to do everything for					
	me.'"						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL		NSTRUCTION 00	COMPL	ETED		
		155291	B. WIN	G		04/21/2	011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS ROAD INDIANAPOLIS, IN46214					
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL I. S.C. IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION	
TAG	3/29/11 6:00 p.m "RepositionedF times" 3/30/11 2:00 p.m self back to lying 3/31/11 11:00 p.m to turning" 4/02/11 2:00 a.m turn from side to 4/05/11 3:00 a.m back to back-refu down, symbol for coccyx area" Resident B had m goals, or interver was unable to he need of staff inter to comply with in feeding himself. A nurse's note, da indicated, "Res. (several pink/purp non-blanchable a and (arrow pointed Areas have appear injuries. Left low buttock: 3 x 3 cm cm, yellow in col 10 cm, left lower pink/purple areas Res. also noted to	Resident refuses at . "Resident will wiggle from back" m. "Resident resistive . "Res has refused to		TAG			DATE	

000188

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
ANDILAN	OF CORRECTION	155291		LDING	00	04/21/2	
		100201	B. WIN		DDDEGG CITY OTHER ZID CODE	0 1/2 1/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
EAGLE \	ALLEY MEADOWS	;		1	APOLIS, IN46214		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	′	ied and order received to					
	send res. to ER (emergency room)."					
	Hospital records	indicate Resident B was					
	-	emergency room on					
		nitted to the hospital on					
	•	ng diagnoses included					
		and severe sepsis.					
	decastas arecis	and bevere sepsis.					
	A hospital Admis	ssion Note, dated 4/12/11,					
	*	ry was obtained by both					
		ECF (Extended Care					
		is discharge from (acute					
	• ,	2/9, the patient has					
	- '	clined in status from					
		y with assistance to being					
		decubitus ulcers and					
		ence. His nutritional					
		shed and per the ECF					
		s. in the last month. He					
		t ability to feed himself.					
	, ,	ek he has had more					
		neIn the last 3 days, he					
	_	d lethargy as well."					
	nas nau mereasec	i lethargy as well.					
	A hosnital Disch	arge Note, dated 4/20/11,					
	indicated:	arge 110te, dated 4/20/11,					
	marcurea.						
	"Admission diag	nosis: Sepsis.					
	Discharge diagno	oses: Septic shock, Sacral					
	pressure ulcers, U						
	rhabdomylosis, diabetes mellitus						
	, , ,						
	Admission Histo	ryHe was also found to					

l	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 04/21/	LETED
	PROVIDER OR SUPPLIER		3017 V	ADDRESS, CITY, STATE, ZIP CODE ALLEY FARMS ROAD APOLIS, IN46214	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	large eschars for progressively we and physical statulcers, a UTI, lost to feed himself debrided 4/15s definitively due with frequent turday) wound charconsulted 4/18, r hydrotherapy/pu packing large ulderessings twice pregular, aggressi At exit on 4/21/11 aprovided no addition or modified nutritions. An Immediatie Jed 4/19/11 ati2:45 p jeopardy began of facility failed tions for weight loss at the rapeutic nutrical aggressing nutritions prevent significates assessing nutritions and physician, not resident and physician, not resident and progressively statement intakents.	lse lavage daily and cer with moist-to-dry per dayverified need for eve wound care" It 4:00 p.m. the facility and documentation of updated and interventions for Resident Depardy was identified on em. The Immediatie and 3/27/11 when tihe ensure a residental risk and not maintaining tional level received and interventions to ent weight loss by not onal needs in a timely				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED			
		155291	A. BUII			04/21/2011			
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE				
NAME OF F	PROVIDER OR SUPPLIER				ALLEY FARMS ROAD				
EAGLE VALLEY MEADOWS				INDIANAPOLIS, IN46214					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION				
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE			
IAG	REGULATORY OR LSC IDENTIFYING INFORMATION) from staff, and not undating the resident's		+	IAG	DET TOTAL TO		DATE		
	from staff, and not updating the resident's								
	dietary care plan. The Direction of Nursing								
	Services, tihe Direction of Nursing Services								
	Specialisti and tihe Executive Direction								
	were notifed of tihe Immediatie Jeopardy								
	on 4/19/11 ati3:20 p.m. of tihe								
	Immediatie Jeopardy relatied tio care and								
	services for pressure ulcer prevention								
	and tireatimentiThe Immediatie Jeopardy was removed on 4/21/11 ati4:50 p.m.								
		•							
	_	servations intierview,							
		s, iti was detiermined							
	tihe facility had implementied tihe plan of action tio remove tihe Immediatie Jeopardy and tihati tihe stieps tiaken removed tihe immediacy of tihe problem Residenti assessmentisauditis of all residenti records by tihe facilityplans of correction for discovered concerns, and employee inservices were reviewed. Residentis witih pressure sores were								
	observed tio asses								
	condition. Even tih								
		removed tihe Immediatie							
	• •	ilitiy remained outi of							
	compliance ati red	·							
	•	solatiedno actiual harm							
	•	r more tihan minimal							
	harm tihati is noti	immediatie jeopardy							
	This federal tag rela	ates to Complaint							

l	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 04/21	e survey pleted /2011		
NAME OF PROVIDER OR SUPPLIER EAGLE VALLEY MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS ROAD INDIANAPOLIS, IN46214					
	VALLEY MEADOWS SUMMARY S (EACH DEFICIEN		3017 V	ALLEY FARMS ROAD	ECTION DULD BE	(X5) COMPLETION DATE		